SOUTH CAROLINA Department OF Disabilities AND Special Needs

DAY SERVICES

Report for Single Plan Development ☐ _____
(date developed)

Service & Treatment Plan ☐ _____
(date developed)

SECTION 1: General Information

A. Day Service Type:

Day Habilitation	☐	
Prevocational	☐	
Rehabilitation Supports	☐	
Other	☐	Specify: _____

B. Funding Source:

MR/RD Waiver	☐	
Medicaid State Plan	☐	
Rehabilitation Supports	☐	
Other	☐	Specify: _____

SECTION 2: Identifying Information

A. Consumer's Full Name: _____

B. Date of Birth: _____

C. Home Telephone Number & Address: _____

D. Primary Contact: _____

SECTION 3: Critical & Emergency Information

A. Critical Information: _____

B. Emergency Disaster Preparedness Plan Information: _____

SECTION 4: Day Service Summary

A. Assessment tool information: _____

B. Assessment results summary: _____

C. Summary of progress and/or regression: _____

D. Proposed Needs & Actions: _____

SECTION 5: Health Information

A. Primary Care Physician _____

B. Hospital of choice _____

C. Medication administration:

- ☐ Consumer
- ☐ Consumer w/ assistance from Direct Support Staff
- ☐ Certified Medication Technician
- ☐ Licensed Nurse

Comments: _____

D. Diet:

- Regular ☐
- Restricted Calories ☐ Explain: _____
- Restricted Foods ☐ Explain: _____
- Pureed ☐
- Chopped ☐

Comments: _____

E. Adaptive Equipment:

Assistive Technology Device or Supplies	Schedule for Use
_____	_____

SECTION 6: Provider Agency Information

A. Provider Agency: _____

B. Person Completing Report: _____

SECTION 7 Six Month Review Summary

A ONLY REQUIRED FOR REHABILITATION SUPPORT SERVICES

- Are current goals and objectives appropriate and effective in meeting the need and goals of the consumer?

  ☐ Yes ☐ No

- Are there any other issues pertinent to the functioning of the consumer?

  ☐ Yes, explain: _____

  ☐ No

- Do the needs of the consumer support the continuation of rehabilitation support services?

  ☐ Yes,

  ☐ No: explain: _____

B. Signature: _____ _____

Lead Clinical Staff Date Reviewed

SECTION 8 Signatures

A. Signatures of persons approving Annual Treatment Plan

I have been provided with and understand the information of the services within this Day Services/Facility Based Rehabilitation Support Treatment Plan. I have participated in the development of this plan and agree to the conditions contained within.

B. Signatures:

_____ _____

Consumer Date

_____ _____

Parent or Guardian (*when necessary*) Date

_____ _____

Staff/LCS Date